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Implementation of the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS

Progress made in the implementation of the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS

Report of the Secretary-General

Summary

The present report summarizes the progress countries have made towards implementation of the commitments set forth in the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS.

The global response to HIV, an important component of which continues to be universal access to prevention, treatment, care and support, has achieved much in recent years. As of December 2008, an estimated 4 million people in low- and middle-income countries were receiving antiretroviral therapy — 10 times more than five years ago. New HIV infections decreased 17 per cent between 2001 and 2008, and the number of pregnant women who received antiretroviral drugs to prevent mother-to-child transmission increased from 10 per cent in 2004 to 45 per cent in 2008. That translates to more than 60,000 at-risk babies born without HIV in 2008 alone. The epidemic is in transition, highlighting the importance of ongoing vigilance regarding the most current modes of transmission within each country and the need for flexibility in national approaches.

In 2007, one in five low- and middle-income countries achieved more than 50 per cent coverage of services to prevent mother-to-child HIV transmission, as well as antiretroviral therapy. New data to be released later this year will likely show an increase in the number of countries achieving their 2010 country targets for universal access to selected HIV-related services. However, many countries are still not on track to achieve their global commitments. The epidemic continues to outpace the HIV response: for every two people starting antiretroviral therapy, five are newly infected. Country targets for universal access by 2010 will be reviewed in 2011.

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HIV remains the leading cause of death among reproductive-age women worldwide. It is a major cause of childhood illness and death in high-prevalence settings, a hurdle to poverty and hunger reduction, and a critical factor in the resurgence of other infectious diseases, especially tuberculosis.

Stigma and discrimination continue to beset people living with HIV and individuals most at risk of infection — men who have sex with men, injecting drug users and sex workers. Social and legal challenges to human rights create significant barriers to an effective national AIDS response in many countries. Effective action within the health sector is essential to stem the spread of HIV and reduce mortality, but a sustainable response must reach further to address punitive laws and the social drivers of the disease.

AIDS response supports other Millennium Development Goals

Millennium Development Goal 6 is to halt and begin to reverse the HIV epidemic by 2015. But unless the international community dramatically accelerates its efforts, we will not meet that target.

Nor will other Millennium Development Goal targets be readily achieved in the absence of an effective AIDS response. Slowing the rate of new infections and HIV-related morbidity and mortality is vital to advancing almost every global development goal.

Reducing HIV infections and providing treatment to those infected so they can live healthy, productive lives is tied into reducing poverty and hunger — Millennium Development Goal 1. Ensuring that the next generation of children is born HIV-free supports Millennium Development Goal 4, on the reduction of child mortality.

HIV programmes help strengthen national health systems, attracting vital new financial resources for health, building systemic capacity and introducing chronic disease management approaches for the first time in many resource-limited settings. Better health-care systems support maternal health — Millennium Development Goal 5 — and reduce leading infectious diseases — Millennium Development Goal 6.

Other Millennium Development Goals support the AIDS response

Conversely, the broad-based gains in health and development sought in the context of the Millennium Development Goals strengthen the impact and sustainability of HIV programmes and policies.

In sub-Saharan Africa, women account for more than 60 per cent of people living with HIV. Global efforts to promote gender equality — the focus of Millennium Development Goal 3 — play an essential role in reducing women's and girls' vulnerability to infection.

Universal education initiatives, as set out in Millennium Development Goal 2, are associated with delayed initial sexual activity and reduced HIV risk behaviours among young women and girls. Strategies to promote food security — Millennium Development Goal 1 — mitigate the epidemic's impact and contribute to the success of antiretroviral therapy. In addition, expanded sexual and reproductive health services as a result of the campaign for Millennium Development Goal 5 are accelerating the scaling up of primary HIV prevention services for women as well as interventions to prevent mother-to-child transmission.

Despite the natural synergies between the AIDS response and the efforts made in connection with other Millennium Development Goals, there has not been sufficient focus on capturing and maximizing these mutually supportive dynamics. With only five years until the Millennium Development Goal deadline, now is the time to take urgent, strategic steps so as to unleash the power, capacity and innovative potential of the AIDS movement, working with all partners and stakeholders to generate synergies that will yield concrete results across the comprehensive development agenda. To help achieve universal access and the Millennium Development Goal targets, the Joint United Nations Programme on HIV/AIDS (UNAIDS) is implementing the "Joint Action for Results: UNAIDS Outcome Framework 2009-2011", a strategic plan that focuses on 10 priority areas.

Recommendations for accelerated progress

The present report provides specific recommendations for accelerating progress towards universal access to HIV prevention, treatment, care and support. They include the following:

(a) Stakeholders in the response must significantly intensify their efforts to prevent new infections by making better use of proven strategies. For example, stakeholders should make a solid commitment to eliminating mother-to-child transmission and optimizing the health of HIV-positive mothers and their families.

(b) As antiretroviral therapy is lifelong, national partners should begin planning now for long-term sustainability, including addressing the inevitable increase in demand for second- and third-line drug regimens.

(c) The HIV response should work actively with partners outside the HIV field to strengthen and leverage the synergies between HIV programmes and other Millennium Development Goals. In particular, HIV programmes should be specifically tailored so as to maximize their support for the strengthening of health-care systems.

(d) Recognizing the long-term benefits that will accrue from investing in HIV programmes, national Governments and international donors should sustain and increase financial contributions to HIV programmes.

(e) In advance of the comprehensive review by the General Assembly of the progress achieved in the global response to AIDS, to be held in 2011, national partners, with support from the Joint United Nations Programme on HIV/AIDS, should undertake open and inclusive consultation processes to review the progress made towards the attainment of country targets for universal access.

I. Introduction

1. Since the HIV epidemic was first identified nearly three decades ago, it has been apparent that an effective response to the disease must extend beyond the health sector. HIV transmission is facilitated by and exacerbates conditions of vulnerability, inequality and social marginalization. Today, HIV remains one of the central threats to global health, international development and stability. Just as an effective HIV response is critical to progress on priority development indicators, broader gains in health and development also help maximize the impact of HIV-specific efforts.

2. The global response to HIV is grounded in the core goals of the Millennium Declaration. Millennium Development Goal 6 includes a resolve to halt and begin to reverse the epidemic by 2015. At the twenty-sixth special session of the General Assembly on HIV/AIDS, held in 2001, Member States unanimously pledged to strive towards a series of time-bound targets for 2010, including a 25 per cent reduction in HIV prevalence among young people between the ages of 15 and 24, ensuring that 95 per cent of all young people have access to the information needed to reduce their vulnerability to HIV, and 80 per cent coverage of services aimed at preventing mother-to-child transmission. At the 2006 High-level Meeting on AIDS, Member States reaffirmed the targets set out in the 2001 Declaration of Commitment on HIV/AIDS and further pledged to achieve universal access to HIV prevention, treatment, care and support by 2010.

3. Between 2006 and 2007, more than 120 countries defined specific universal access targets for 2010. Targets for "universal access" do not necessarily require 100 per cent coverage of services. While the ultimate goal is the increased uptake and sustained use of equitable, accessible and affordable services, experience has shown that some of the people who are offered services such as testing or treatment may choose not to use them. This is particularly true in situations where stigma, discrimination and violence against people living with HIV, women and marginalized populations are common. The national targets for universal access reflect the commitment of country-level partners to obtaining sufficient service coverage to sharply alter the epidemic's trajectory and to deliver concrete results for people in need.

4. The present report to the General Assembly on the implementation of global HIV commitments describes the progress made to date, identifies weaknesses and shortcomings in the context of current efforts, and recommends urgent action to advance towards the global goal of halting and beginning to reverse the epidemic. To ensure the long-term sustainability of a robust response, the report emphasizes the mutually supportive relationship between the HIV response and the broader development agenda, especially the Millennium Development Goals, and the need to strengthen linkages between those diverse efforts.

The epidemic: a status report

5. As of December 2008, an estimated 33.4 million (31.1 million to 35.8 million) people were living with HIV, including 2.7 million people (2.4 million to 3 million) who were newly infected in 2008 alone.

6. Dramatic gains have been made in expanding access to HIV treatment, and the annual number of new infections is more than 17 per cent lower than it was in 2001.

The HIV response is also helping drive a historic increase in financial resources for broader health-care programmes in low- and middle-income countries.

7. However, that progress has not been sufficient to profoundly alter the course of the epidemic. HIV remains the leading infectious-disease killer in the world and the leading cause of death among women of reproductive age (15 to 49). Nearly three decades after the epidemic was first identified, stigma, discrimination and punitive laws continue to undermine efforts to prevent new infections, with notably destructive effects on efforts to address the needs of people who inject drugs, men who have sex with men, and sex workers and their clients. Service coverage for populations in humanitarian crisis situations needs to be more consistent and better coordinated. The epidemic continues to outpace the response, with five new infections occurring for every two individuals who begin antiretroviral therapy.

8. HIV is having especially pronounced effects in southern Africa, home to the nine countries with the highest HIV prevalence.[1] In Swaziland, which has the world's highest HIV prevalence, HIV has halved average life expectancy, effectively erasing decades of development gains. In South Africa, life expectancy has fallen by almost 20 years since 1994, primarily as a result of HIV. While the epidemic's effects are most severe in sub-Saharan Africa, no region across the world has been spared.

9. The epidemic continues to evolve, a fact that highlights the importance of ongoing vigilance and flexibility in national approaches. For example, in South Asia and numerous countries of sub-Saharan Africa, new epidemiological patterns have emerged, with older adults in stable, long-term relationships representing a growing proportion of people newly infected. In Lesotho, an estimated 62 per cent of incident infections in 2008 were among adults in long-term relationships.

10. In sub-Saharan African countries, recent studies have consistently found high levels of HIV prevalence among men who have sex with men, ranging from 10 per cent to 43 per cent, and modelling exercises carried out in several countries have suggested that sexual transmission among such men may constitute up to 15 per cent of all new infections. In China in 2007, an estimated 11 per cent of new infections occurred among men who have sex with men. In Peru in 2009, over 50 per cent of new infections were estimated to have occurred among men who have sex with men. In the United States of America, the proportion of new infections among men who have sex with men has been rising since the early 1990s, and, by 2006, constituted the largest fraction of new HIV infections, a pattern that has also been seen in a number of other western countries.

Important progress towards reversing the epidemic and enduring challenges

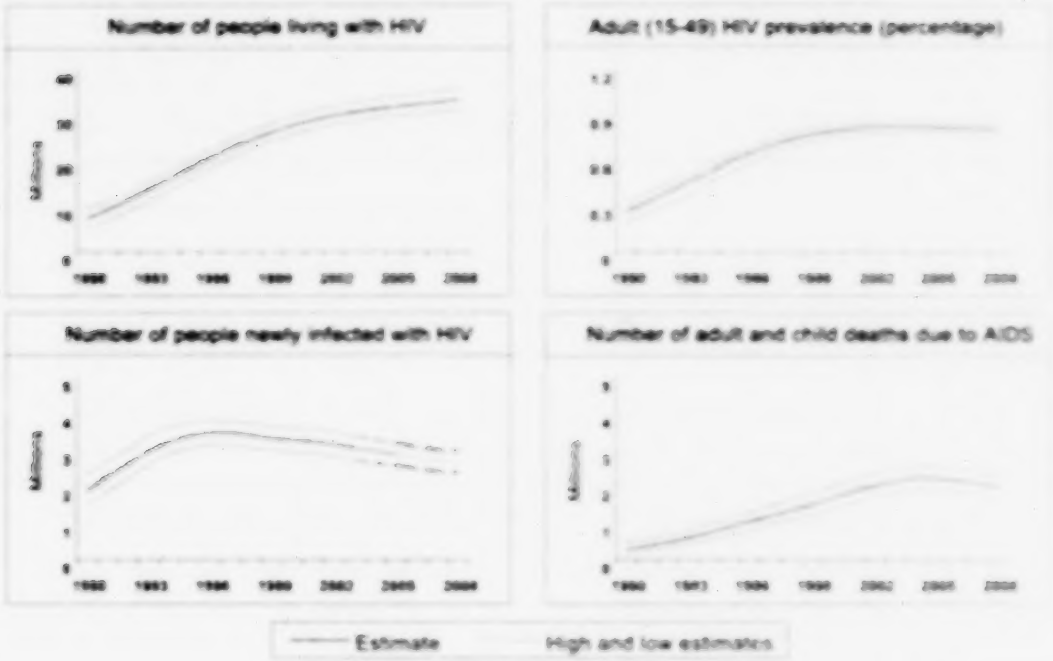
11. Recent evidence indicates that global solidarity and leadership in the response has resulted in important gains, as set out below:

(a) Globally, the rate at which new infections are occurring has slowed (see fig. I). Since 2001, there has been a 17 per cent reduction in the annual number of new infections. An increasing number of countries, including Cambodia, the

[1] Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe.

Dominican Republic, Mali, the United Republic of Tanzania and Zimbabwe, are reporting declines in HIV incidence or prevalence.

Figure I
HIV: global estimates, 1990-2008

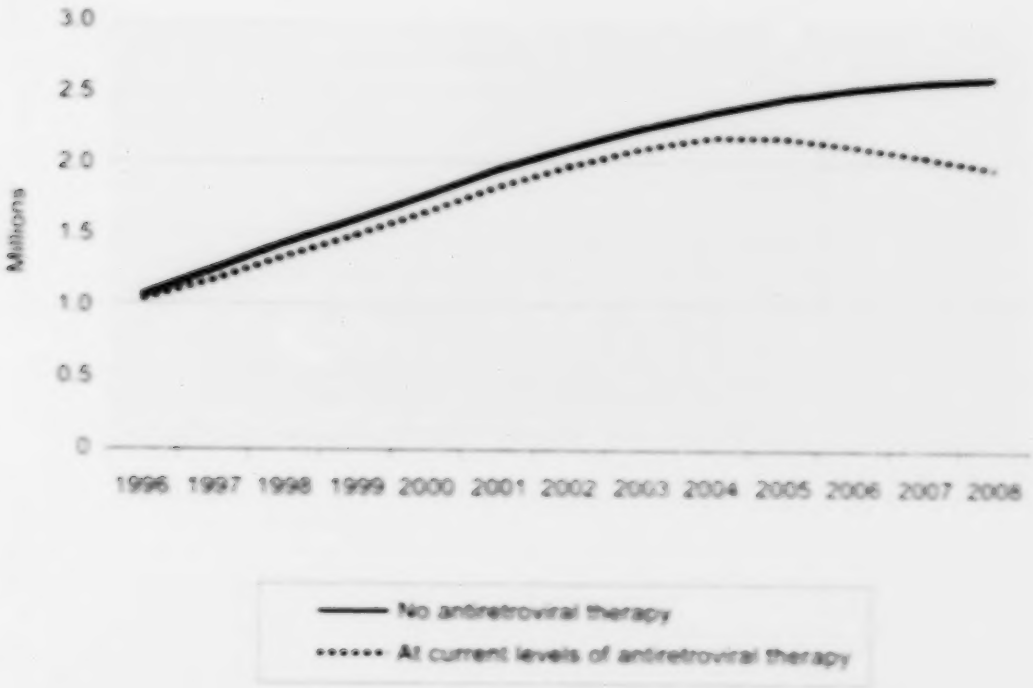

Number of people living with HIV
Adult (15-49) HIV prevalence (percentage)
Number of people newly infected with HIV
Number of adult and child deaths due to AIDS
Estimate
High and low estimates

Source: Joint United Nations Programme on HIV/AIDS/World Health Organization.

(b) With 4 million people on antiretroviral therapy in low- and middle-income countries at the end of 2008 — a tenfold increase in five years — advances in the area of access to treatment are estimated to have saved 1.4 million lives since 2004, 1.1 million of them in sub-Saharan Africa (see fig. II). The number of children under 15 years of age and receiving antiretroviral therapy reached approximately 275,700 by the end of 2008, a 3.5-fold increase over 2005.

Figure II

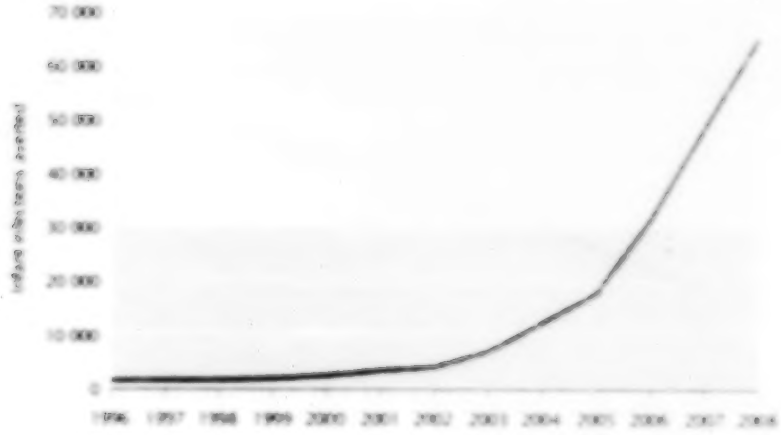
Estimated number of AIDS-related deaths with and without antiretroviral therapy, globally, 1996-2008



(c) Coverage of antiretroviral regimens to prevent mother-to-child transmission reached 45 per cent in 2008, compared with 10 per cent in 2004. To date, 19 countries have already achieved national universal access targets of at least 80 per cent coverage for services to prevent mother-to-child transmission (see fig. III). Such services benefit not only newborn children but also mothers, partners and affected families.

Figure III

Estimated annual number of infant infections averted through the provision of antiretroviral prophylaxis to HIV-positive pregnant women, globally, 1996-2008



(d) Even in the face of enormous economic challenges, courageous acts of leadership continue to inspire sustained solidarity in the HIV response. For example, in South Africa, the country with the largest number of people living with HIV, the Government pledged in February 2010 to dramatically expand access to evidence-informed prevention and treatment programmes.

(e) All 13 priority countries for the scale-up of adult male circumcision services aimed at HIV prevention have conducted situation analyses, and several have finalized national guidelines to accelerate access to voluntary circumcision. Kenya aims to achieve universal access to male circumcision services by 2013, while Zambia has established a target of circumcising 250,000 men annually.

(f) In 2008, an estimated $15.6 billion from all sources was invested in the response for low- and middle-income countries, a 39 per cent increase over 2007.

12. However, despite those favourable trends, overall progress towards halting and beginning to reverse the HIV epidemic continues to lag:

(a) The number of new infections is increasing again in Eastern Europe and Central Asia, where there were an estimated 87,000 incident infections in 2008, more than three times as many as the 26,000 estimated to have occurred in 2001. Although HIV prevalence has stabilized in southern Africa, the dimensions of the epidemic remain catastrophic in that subregion;

(b) Four of five low- and middle-income countries are not on track to achieve nationally and internationally agreed targets for universal access to prevention, treatment, care and support. Antiretroviral treatment coverage remains far short of universal access in most countries. For example, in the Middle East and North Africa, only 14 per cent of people in need of treatment receive it. In addition, the majority of women and newborns still lack access to services to prevent mother-to-child transmission, and access to services remains unacceptably limited for key populations that are at higher risk of HIV infection. The epidemic continues to

outpace the HIV response; for every two people starting antiretroviral therapy, five are newly infected;

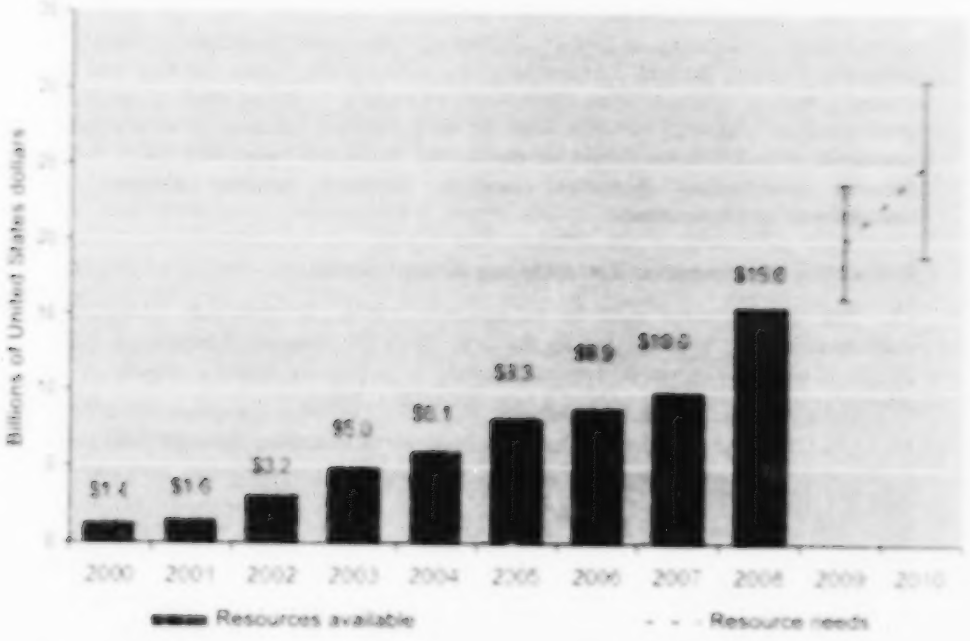
(c) With people under age 25 accounting for more than 40 per cent of new infections, surveys continue to reflect only modest gains in comprehensive HIV-related knowledge among young men and women aged 15 to 24 years. Less than 40 per cent of young men and women have accurate knowledge about HIV transmission, far short of the 95 per cent target set out in the Declaration of Commitment;

(d) The Declaration of Commitment based the response on the realization of human rights and fundamental freedoms for all, but this remains unfulfilled in many countries. In 2008, one in three countries had yet to enact a law prohibiting discrimination against people living with HIV, and most countries did not have legislation to protect from discrimination men who have sex with men, sex workers and their clients, or people who use drugs. Nearly 3 out of 10 countries lack laws or policies to prevent violence against women, especially sexual violence;

(e) To achieve universal access to prevention, treatment, care and support, total annual investments in the response must reach $25.1 billion, roughly 40 per cent more than the total investments made in 2008 (see fig. IV).

Figure IV

Estimated annual HIV resources available for 2000 to 2008 and estimated resources needed for 2009 and 2010



13. The enduring worldwide economic difficulties potentially imperil both the gains achieved thus far as well as efforts to close coverage gaps. According to the World Bank, 40 per cent of low- and middle-income countries are highly exposed to the global economic crisis, limiting their resources for the response. Recent forecasts by the Organization for Economic Cooperation and Development (OECD) indicate that OECD countries are expected to fall $21 billion short of the pledges they have made for international development assistance in 2010.

14. Surveys performed in 2009 of Joint United Nations Programme on HIV/AIDS (UNAIDS) country coordinators, civil society organizations and key donors indicate that the financial crisis is having tangible negative effects on the response in most low- and middle-income countries. The findings have been confirmed by 12 country case studies. A total of 59 per cent of respondents surveyed said that they anticipated reductions in financial support for prevention services over the next 12 months as a result of the financial crisis, with 21 per cent expecting cuts in treatment services. Expected funding reductions are most often reported in countries that need assistance the most: low-income countries with an HIV prevalence exceeding 5 per cent.

15. Recent economic challenges, while of real concern, must not be a reason for cutting essential funding for the response. Such investments need to build on what has been achieved to date. HIV spending is a down payment on a healthy future, yielding immense benefits for future generations, reducing human suffering and averting the large economic and development costs associated with the epidemic.

16. Numerous examples underscore the fact that economic difficulties need not deter the global community from upholding its health and development commitments. According to OECD, at least nine European countries — Belgium, Denmark, Finland, Ireland, Luxembourg, the Netherlands, Spain, Sweden and the United Kingdom of Great Britain and Northern Ireland — are on track to reach the 2010 goal of allocating 0.7 per cent of their national income to development assistance. The executive budget of the United States for fiscal year 2011, while freezing discretionary domestic spending, included notable increases for international health assistance.

Redoubling the commitment to achieving defined results

17. The world's focus must be on concrete results. To that end, UNAIDS is implementing the "Joint Action for Results: UNAIDS Outcome Framework 2009-2011", a new collaborative approach aimed at achieving specific results in 10 priority areas that form the core of a new UNAIDS strategy.

18. UNAIDS and its partners have pledged to take action, through intensified collaboration and programmatic focus, to help achieve the outcomes necessary to stem the HIV epidemic (see box below). All 10 priority areas are critical to the achievement of universal access, and success in each of them will contribute to reaching the Millennium Development Goals as well as support the broader development agenda.

UNAIDS Outcome Framework 2009-2011: priority areas

- Reduce sexual transmission of HIV
- Prevent mothers from dying and babies from becoming infected with HIV
- Ensure that people living with HIV receive treatment
- Prevent people living with HIV from dying of tuberculosis
- Protect drug users from becoming infected with HIV
- Protect men who have sex with men, sex workers and transgender people from becoming infected with HIV
- Remove punitive laws, policies, practices, stigma and discrimination that block effective responses to AIDS
- Stop violence against women and girls
- Empower young people to protect themselves from HIV
- Enhance social protection for people affected by HIV

19. At the national level, the Outcome Framework will enable the United Nations and its partners to strengthen and refocus their response so as to achieve results. The Outcome Framework builds on previous efforts to align the agendas of UNAIDS co-sponsors and the Secretariat to mandate clear deliverables, maximize impact, use comparative strengths and support national priorities.

II. HIV and the Millennium Development Goals: linking the HIV response to broader health and development efforts

20. The Millennium Development Goals aim to reduce extreme poverty and unleash the potential of individuals, communities and societies that have been burdened by hunger, disease and inadequate access to basic services. Where the HIV response has been most successful, it has catalysed and built on profound societal changes, including the full engagement of civil society and the embracing of a rights-based health agenda, as envisaged in the Millennium Declaration.

Synergistic relationship between the HIV response and efforts made to achieve other Millennium Development Goals

21. The results achieved in the response to HIV extend across the Millennium Development Goals (see table below). To accelerate progress and ensure the sustainability of efforts, concrete steps are urgently required to maximize the synergies between HIV-specific and non-HIV-related health and development initiatives.

22. Broader development efforts alleviate the factors that increase vulnerability to infection and reduce the impact of HIV programmes, such as gender inequality, limited access to education, income inequality, food insecurity and malnutrition, and weak health and social protection systems. Similarly, the HIV response, with its

unmatched grass-roots base, has much to offer the broader development agenda. To leverage the response in such a way as to catalyse broader development gains, Governments, multilateral organizations, the private sector and civil society must take steps to activate that potential while maintaining sufficient specificity to address the unique challenges posed by the epidemic.

23. The expanding partnership between UNAIDS and the Millennium Villages Project exemplifies, at the project level, the potential benefits of a closer partnership between the response and broader development efforts. Within the $110 per capita investment target for the Millennium Villages, UNAIDS and its development partners are working to create "mother-to-child-transmission-free zones", where no newborn becomes infected with HIV, while pursuing a comprehensive array of additional development aims.

Potential impact of the AIDS response on the various Millennium Development Goals

Millennium Development Goal	*Impact of the AIDS response*
Goal 1: Eradicate extreme poverty and hunger	• The provision of antiretroviral therapy improves labour productivity, leads to economic benefits and prevents children from becoming orphans • HIV prevention decreases household vulnerability to poverty and hunger • HIV care and support help reduce children's vulnerability to hunger • HIV mitigation can lead to improved health and nutrition in HIV-affected households
Goal 2: Achieve universal primary education	• Support for orphans and other vulnerable children allows them to attend school and benefit from other training • Provision of antiretroviral therapy to parents living with HIV helps ensure that they can continue to send their children to school • Antiretroviral therapy and prevention help maintain an adequate pool of schoolteachers
Goal 3: Promote gender equality and empower women	• Empowers women by highlighting gender inequalities and promoting gender-sensitive HIV interventions, including the promotion of sexual and reproductive health and rights; education programmes in schools and communities on HIV, sexuality and gender-based violence; sexual and reproductive health services for the general population and vulnerable persons; support for children, the elderly and the sick, which allows women to work; the promotion of women's economic security • Social protection programmes for orphans and vulnerable children help ensure that girls are not disadvantaged in terms of their access to education
Goal 4: Reduce child mortality	• The prevention of mother-to-child HIV transmission increases child survival through a reduction in paediatric infections; care for HIV-exposed children; support for infant-feeding practices and growth monitoring; nutrition; other child survival interventions (e.g., vitamin A, immunizations)

Millennium Development Goal	*Impact of the AIDS response*
	• AIDS funding contributes to the strengthening of health-care systems, leading to improved child health services
Goal 5: Improve maternal health	• Preventing mother-to-child HIV transmission increases maternal survival through the provision of antiretroviral therapy to pregnant women; the promotion of linkages with and referrals to antenatal care, maternal and child health and full sexual and reproductive health; and the provision of antenatal syphilis screening and treatment
	• Voluntary counselling and testing increases maternal survival through the provision of basic sexual and reproductive health services, and the promotion of linkages with and referrals to antenatal care, maternal and child health and a full sexual and reproductive health package
	• HIV-prevention activities contribute to improving sexual and reproductive health
	• AIDS funding contributes to the strengthening of health-care systems leading to improved maternal health services
Goal 6: Combat HIV/AIDS, malaria and other diseases	• HIV services contribute to a reduction in the prevalence of malaria and associated mortality/morbidity through the provision of intermittent presumptive therapy for pregnant women in programmes for the prevention of mother-to-child transmission; the provision of insecticide-treated bed nets to pregnant women, mothers and children in such programmes; and the provision of bed nets through HIV home-based-care programmes
	• AIDS funding contributes to the strengthening of health-care systems, leading to improved services for malaria control
	• Screening HIV patients for tuberculosis reduces the transmission of tuberculosis, provides an opportunity to administer preventive therapy or treatment and reduces mortality/morbidity associated with tuberculosis
	• AIDS funding contributes to the strengthening of health-care systems, leading to improved health services and improved detection and treatment of other diseases
Goal 8: Develop a global partnership for development: access to affordable essential drugs	• The campaign on access to AIDS drugs has led to price reductions in generic medicines for other diseases; increased financing for other medicines; improved supply chains; improved quality standards; stimulated research and development for other diseases; and stimulated adaptations, for example, paediatric and fixed-dose combinations

Poverty, food insecurity, malnutrition and HIV (Goal 1)

24. The HIV response supports the global campaign to eradicate extreme poverty and hunger (Goal 1). HIV deepens poverty and increases food insecurity, frequently reducing labour productivity, household income and agricultural potential. Infection also increases the body's need for nutrients, reduces food intake and impedes nutrient absorption. Preventing new infections averts the negative economic consequences of the disease for vulnerable households, communities and societies,

while life-saving treatment preserves household productivity and enhances food security.

25. Conversely, initiatives aimed at reducing poverty and hunger also help reduce vulnerability to HIV and magnify the impact of HIV-specific interventions. Focused, HIV-sensitive strategies aimed at alleviating income inequality help reduce vulnerability to HIV infection. Food programmes benefit the response, as malnutrition weakens the immune systems of people living with HIV and can accelerate disease progression. Proper nutrition plays a central role in antiretroviral therapy, as malnourished individuals on antiretrovirals are two to six times more likely to die than properly nourished patients. According to a recent study in Zimbabwe, nutritional interventions significantly improve antiretroviral treatment adherence and result in marked weight gain for people living with HIV.

26. Broad-based social protection initiatives reduce the economic, educational and health vulnerability of children and young people who are orphaned or made vulnerable by AIDS. A study of cash-transfer programmes in Zambia found that when poverty-stricken homes are targeted using AIDS-sensitive criteria, including labour-constrained households and those with orphans, 75 per cent of AIDS-affected households are reached.

Universal education and HIV (Goal 2)

27. The response is also closely linked with the push for universal education under Goal 2. The scale-up of antiretroviral treatment in high-prevalence countries is helping slow the loss of teachers and educational administrators due to illness and death. Support programmes financed through the response also help to maintain educational access for children who have been orphaned or made vulnerable by the epidemic.

28. The achievement of Goal 2 also offers tangible benefits for the response. A recent analysis of studies conducted since 1996 found a clear relationship between lower educational levels and increased risk of infection. In particular, universal education would help to reduce the vulnerability of adolescent girls and young women, as studies have consistently found that educational attainment is strongly associated with delayed initial sexual activity and delayed marriage. The education sector has an enormous potential to reduce vulnerability for young people who are most at risk, especially those who inject drugs, young men who have sex with men, and young people who engage in sex work, especially in regions where those are the groups of young people most affected by the epidemic. There is a growing recognition of the fact that efforts to achieve the "education for all" goal of universal primary education must be closely linked with interventions that support gender equality in education, address the educational needs of young people and adults through appropriate learning and life-skills programmes, and reduce illiteracy, in particular among women. The education sector has a critical role to play both in preventing HIV and in building the capacity to respond, by promoting human rights, gender equality, knowledge and skills, and the participation of young people and people living with HIV, and by reducing stigma and discrimination.

Gender and HIV (Goal 3)

29. As profound gender inequalities represent one of the key drivers of the epidemic, the global campaign for gender equality (Goal 3) is intricately linked to

success in the response. Women lack equal access to the economic benefits of their labour; in Kenya, for example, although women represent 70 per cent of the agricultural workforce, only 1 per cent of them own the land that they farm. Women frequently have no means of advocating for themselves or of seeking political change; globally, women account for only 17 per cent of parliamentarians, with substantially lower proportions in many countries. Because women, who represent two thirds of the world's 752 million illiterate people, lack equal access to basic education, many are unable to access and benefit from potentially life-saving HIV education.

30. The effects of gender inequality compound women's heightened vulnerability to HIV. As a result of the profound social, legal and economic disadvantages they face, women often have no way of abstaining from sex or of insisting that their partners use a condom. In sub-Saharan Africa, women account for more than 60 per cent of people living with HIV.

31. Violence against women increases women's vulnerability. In a four-country study, nearly one in four women reported that their first episode of sexual intercourse had been forced. In surveys carried out in Bangladesh, Ethiopia, Peru, Samoa, the United Republic of Tanzania and Thailand, between 40 per cent and 60 per cent of women reported having been physically or sexually abused by their partners.

32. Addressing gender inequality is perhaps one of the most effective strategies available to reduce vulnerability and enhance the capabilities of individuals, households and communities with respect to coping with the impact of HIV. Indeed, experience has demonstrated that reducing gender inequality frequently leads to rapid, sustained improvements in public policy and to reductions in individual vulnerability. In Rwanda, where women occupy 56 per cent of parliamentary seats, legislation has been enacted to prevent gender-based violence, recognize women's inheritance rights and grant women the right to work without their spouse's authorization.

33. The response has resulted in tangible benefits for broader efforts to empower women, highlighting the negative effects of gender inequality and promoting gender-sensitive policies and programmes. Scaling up services to prevent mother-to-child transmission has strengthened antenatal care in resource-limited settings, while strengthened linkages between HIV and sexual and reproductive health services contribute to HIV prevention. Preventing unintended pregnancy in women living with HIV through strengthened family planning services contributes to the elimination of mother-to-child transmission. HIV funding has also supported the expansion of services for female sex workers, including sexual and reproductive health services.

34. Evidence suggests that closer linkages between gender-focused and HIV-specific programmes have important synergistic benefits. In South Africa, the integration of gender and HIV training into a microfinance initiative was associated with reductions in partner violence among programme participants, as well as with improvements in economic well-being, social capital and personal empowerment.

HIV and the health-related Millennium Development Goals (Goals 4, 5 and 6)

35. Because HIV-related complications cause more deaths each year than any other infectious disease, a robust response is required not only to halt the epidemic but also to improve other global health outcomes. In addition to accelerating progress towards the achievement of Goal 6, which specifically focuses on HIV, tuberculosis, malaria and other infectious diseases, HIV-related programmes support efforts to improve child and maternal health (Goals 4 and 5, respectively). According to recent analyses of country data, progress towards achieving the full array of health-related Millennium Development Goals is directly correlated with national HIV prevalence.

36. The HIV response helps prevent newborns and young children from dying, contributing to the global goal of reducing under-5 mortality by two thirds by 2015. Through the end of 2008, HIV programmes had prevented at least 200,000 infants (including 134,000 in sub-Saharan Africa) from becoming infected in the womb, during delivery or as a result of breastfeeding. Treatment programmes also deliver antiretroviral therapy to HIV-positive children, 50 per cent of whom would die within the first two years of life if not treated. In 2008 alone, paediatric treatment coverage increased by 39 per cent. Conversely, initiatives under Goal 4 build service infrastructure that supports the early diagnosis and regular monitoring of paediatric infection, as well as proper nutrition for children living with HIV.

37. The process of achieving Goal 5 is lagging behind that of the other health-related Goals. As HIV causes more deaths among reproductive-age women worldwide than any other health condition, the links between the response and Goal 5 are clear. During a five-year period in which antiretroviral therapy was introduced in the KwaZulu-Natal province of South Africa, deaths among women aged 25 to 49 fell by 22 per cent. The steady expansion of services for the prevention of mother-to-child transmission has increased opportunities for early diagnosis and the timely initiation of therapy among women of reproductive age, which is in accordance with the new 2009 World Health Organization (WHO) guidelines for the prevention of mother-to-child transmission. Achieving Goal 5 benefits the HIV response by strengthening and expanding primary health services for women and children.

38. Within the framework of Millennium Development Goal 6, HIV programmes have promoted efforts to control other infectious diseases, most notably tuberculosis. Because an estimated 1.4 million people living with HIV had active tuberculosis in 2008, the HIV epidemic is driving a resurgence of tuberculosis in areas with high HIV prevalence. Antiretroviral therapy significantly reduces the likelihood that co-infected patients will develop active tuberculosis. Similarly, tuberculosis-care settings offer essential venues for HIV services; in 2008, 22 per cent of tuberculosis patients worldwide were tested for HIV.

39. The response also produces broad-based health benefits in low- and middle-income countries by strengthening fragile health systems. Global health initiatives that address specific priority diseases have accelerated access to and uptake of services, attracted substantial new health financing in resource-limited settings, facilitated improved community participation in public health governance, increased in-service training opportunities for health workers, strengthened procurement and supply management systems, and increased demand for improved health information. An expert panel convened by WHO called for priority action steps to

accelerate the joint effectiveness of global health initiatives and national health systems, including the alignment of planning processes to leverage global health initiatives to strengthen health-care systems, an increase in overall health-care financing, and the generation of more reliable data on health systems strengthening.

Stronger partnerships for development (Goal 8)

40. Consistent with the call in Millennium Development Goal 8 for a new global partnership for development, the HIV response has given rise to pioneering partnerships for health. The 2001 Declaration of Commitment led to the establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria, a path-breaking international partnership that through January 2010 had approved more than $19.1 billion in funding for health programmes. An independent evaluation in 2009 found that the Global Fund had emerged as an effective channel for health-care financing. Nevertheless, although more than 50 international donors have made financial contributions to the Fund, the organization is currently facing a gap between available resources and actual needs of at least $4 billion. In October 2010, the international community will gather for a critical replenishment meeting to address the Global Fund's long-term financing needs.

41. With funding from an international airline tax, UNITAID is supporting HIV treatment for more than 226,000 children and supplying second-line antiretroviral drugs to more than 59,000 patients in 25 countries. To meet the long-term demand for resources for the response and achievement of the Millennium Development Goals, concerted leadership is needed in order to strengthen existing financing mechanisms and develop new and innovative financing systems.

42. Through other innovative and visionary partnerships, the response has fundamentally altered longstanding practice with regard to access to essential medicines. Over the last decade, the HIV community has spearheaded a global shift towards differential pricing of medicines and other health products. That momentous change was achieved through a pioneering collaboration among people living with HIV, the pharmaceutical industry, generic-drug producers, international donors, national Governments and global opinion leaders. The response is driving the development of new types of partnerships to expand access to treatment, such as the possible establishment of regional drug registration facilities and manufacturing capabilities in Africa and other regions.

Capturing "positive synergies" between the HIV response and broader development efforts

43. While synergies are apparent between the HIV response and the broad array of Millennium Development Goals, greater efforts are needed to maximize such synergistic effects through coordinated planning and a closer alignment of policies and programmes. For example, the strengthening of health-care systems must become a focus of HIV-specific efforts. Already there are signs of movement in that direction. In 2009, the Global Fund to Fight AIDS, Tuberculosis and Malaria solicited country proposals for a broader-based strengthening of health-care systems. The United States has also taken steps to leverage the President's emergency plan for AIDS relief to strengthen national health systems. In addition, other non-health systems, including social protection services, communities and

educational systems, will also need to be strengthened to enable them to play an optimal role in the long-term response.

44. In order to better link HIV and non-HIV health programmes, flexibility and adaptation will be required within the response. New performance indicators and methodologically robust studies are needed to build the evidence base for simultaneous action so as to accelerate the response while strengthening health and non-health systems. HIV advocates will also need to forge new and broader strategic alliances to promote coordinated action on an expansive range of priority health and development issues.

III. Accelerating progress towards universal access: a critical bridge to reaching the Millennium Development Goals

45. Universal access to HIV prevention, treatment, care and support represents an essential bridge towards achieving the full range of Millennium Development Goals. While working to capture and maximize the synergies between the response and the broader Millennium Development Goal agenda, the international community must redouble its commitment to achieve results in the response.

Prevention as the mainstay of the response

46. Although both the Declaration of Commitment and the Political Declaration state that "prevention must be the mainstay of our response", in many countries the efforts made to date have fallen far short of that vision. Increasing the impact of prevention programmes is essential to preserve the long-term sustainability of treatment initiatives and prevent the epidemic from further undermining the gains made across the broader development agenda.

47. The epidemic's continued expansion stems from the frequent failure to apply proven prevention strategies tailored to the current realities of local epidemics, as well as the chronic and continuing underinvestment in evidence-informed prevention strategies. In 2007, countries spent on average only 21 per cent of HIV-related resources on efforts to prevent new infections. UNAIDS estimates that, to achieve universal access to HIV prevention, treatment, care and support, prevention spending should constitute approximately 45 per cent of global resources for the response, although the optimal share of spending allocated to prevention will vary between and within countries.

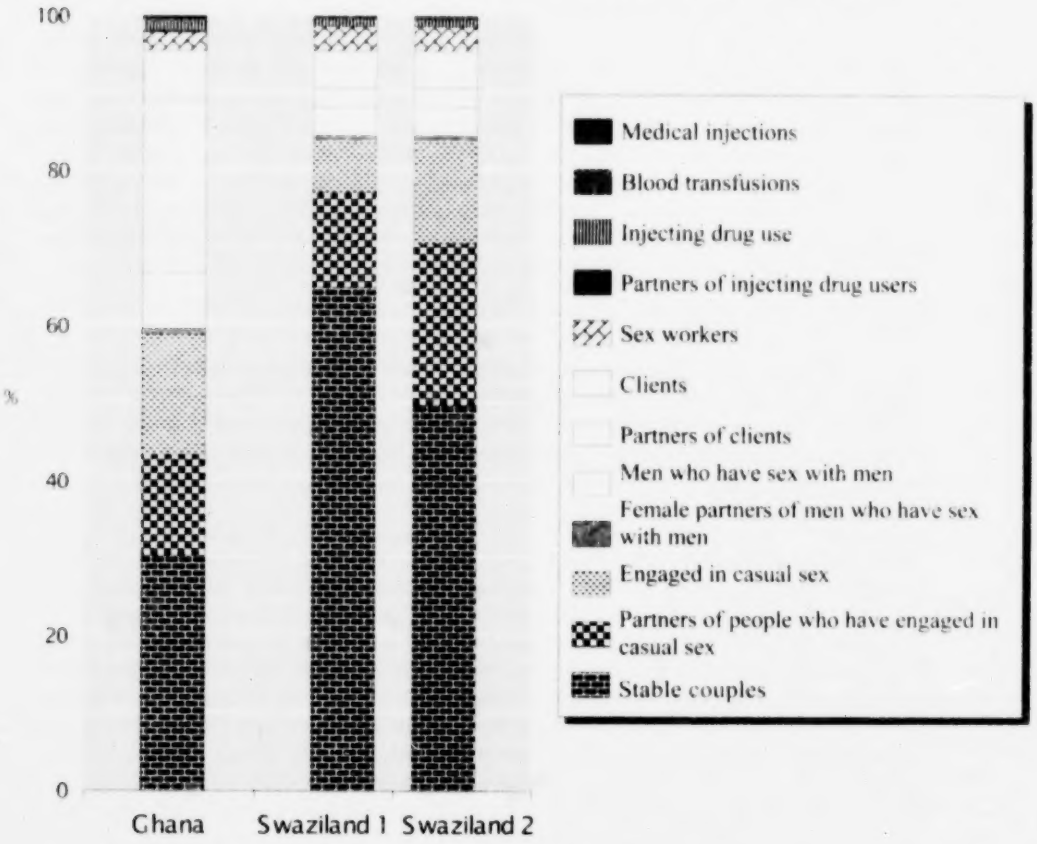
"Combination prevention"

48. It is widely recognized that "combination prevention" is the optimally effective prevention approach for reducing the number of new infections. Combination prevention programmes are rights-based, evidence-informed, community-owned programmes that use a strategic mix of biomedical, behavioural, social and structural interventions that are tailored to meet the prevention needs of individuals and communities.

49. To implement sound combination prevention programmes, decision-makers need reliable, up-to-date information on epidemics and on their response. To build the evidence base for action, UNAIDS has commissioned research quantifying and characterizing HIV incidence by modes of transmission in countries such as Ghana

and Swaziland (see fig. V). By comparing epidemiological trends with national prevention priorities in each country, researchers have identified serious gaps and weaknesses in national prevention efforts, including a common failure to focus resources on the populations contributing the largest share of new HIV infections. Programmes that focused on people who inject drugs, men who have sex with men, and sex workers and their clients were often found to be especially inadequate in many countries. In addition, the studies revealed that national prevention priorities in several countries in sub-Saharan Africa had not effectively adapted to important epidemiological shifts, such as the increased percentage of older adults in stable, long-term relationships among newly infected people in several parts of the region.

Figure V
Distribution of new infections by mode of exposure in Ghana and Swaziland, 2008



Note: The sensitivity analysis for Swaziland used different data sources.
Sources: Bosu et al. (2009) and Mngadi et al. (2009).

50. Although combination prevention is not a new idea, it has yet to be rigorously implemented in most countries. Even though young people account for more than 40 per cent of new infections worldwide, informants reported that school-based

prevention programmes for highly affected districts in 2008 had been implemented in only 51 per cent of the 147 countries surveyed.

51. In particular, efforts to slow the spread of HIV are undermined by a severe underinvestment in evidence-informed programmes that promote and support long-term social change to facilitate HIV prevention or that address the societal or structural factors that increase vulnerability. Structural interventions for HIV prevention can be effective, as demonstrated by a combined microfinance, education and empowerment programme for women that was piloted in South Africa. Prevention programmes that have used a community empowerment approach have also proved effective in reducing risk behaviours among sex worker communities in the Dominican Republic and in India.

52. While major gaps remain in the biomedical toolkit for HIV prevention, meaningful gains have been made towards developing and implementing new prevention tools. Several high-prevalence countries are expanding access to adult male circumcision services. For the first time, a clinical trial in 2009 found promising results for a candidate HIV vaccine that appeared to reduce the risk of infection by a modest but meaningful 30 per cent. Globally, seven clinical trials are under way to assess the safety and efficacy of pre-exposure antiretroviral prophylaxis, and results from the earliest efficacy trials are anticipated soon. Although trial results in December 2009 failed to find that the PRO 2000 candidate microbicide was efficacious, there is considerable positive momentum in this research field, with multiple efforts under way to study microbicide products that incorporate antiretroviral drugs.

HIV prevention and human rights

53. During the past year, important advances have been made in the promotion and protection of the human rights of people living with or affected by HIV. Several countries, including the Czech Republic, the Republic of Korea and the United States, have recently taken steps to lift HIV-related travel restrictions. The High Court in New Delhi struck down a law criminalizing sexual contact between persons of the same sex.

54. Yet despite such progress, human rights violations continue to undermine efforts to prevent people from becoming infected. More than 30 countries have enacted HIV-specific laws that criminalize HIV transmission or exposure, and more than two dozen countries have used non-HIV-specific laws to prosecute individuals on similar grounds. Even as a growing body of data has documented elevated HIV prevalence among men who have sex with men in all regions, a number of countries have undermined effective HIV prevention for this most-at-risk population by either enacting or considering legislation to criminalize same-sex sexual conduct. Scores of countries prohibit or limit access to proven harm-reduction services for people who use drugs. Such punitive and coercive policies are both counterproductive from a public health perspective and antithetical to the human rights basis of effective prevention.

55. The enduring climate of stigma and discrimination in many parts of the world impedes progress towards a critical prevention aim — the meaningful involvement and leadership of people living with HIV in prevention programmes. The Global Network of People Living with HIV/AIDS and UNAIDS are jointly promoting a new rights-based approach to the role of people living with HIV in prevention

programming, known as "Positive Health, Dignity and Prevention". That approach calls for holistic efforts to involve people living with HIV in prevention programmes and intensify action to protect and promote their human rights, combat stigma and discrimination, and link prevention efforts to stronger action to ensure access to treatment and care.

Continued, but fragile, progress in expanding treatment access

56. The remarkable expansion of antiretroviral treatment in low- and middle-income countries during the last decade represents one of the pre-eminent achievements in modern global health and development history. As a result of international solidarity in the context of the response, national leadership and the contributions of diverse stakeholders, a diagnosis with HIV no longer need be a death sentence in resource-limited settings.

57. The benefits of expanded treatment access are far-reaching. In many parts of the world, antiretroviral treatment programmes represent the first broad-scale introduction of chronic disease care for adults. Advocates for attention to other health needs in resource-limited settings, such as heart disease and cancer, are citing the success achieved in the expansion of access to HIV treatment as both an inspiration and a precedent for introducing programmes for the management of other chronic conditions. Treatment programmes are ushering in revolutionary changes in many settings, creating new systems for procurement and supply management, establishing new clinical and operational practices, and changing health-seeking behaviours and the long-term expectations of clients.

58. Recent evidence indicates continued progress in scaling up antiretroviral treatment, with global coverage increasing by 36 per cent in 2008 alone. Taking into account evidence regarding the clinical benefits of the earlier initiation of antiretroviral therapy, WHO in 2009 announced new treatment guidelines that recommend starting therapy once a patient's CD4 count falls below 350 cells/mm3, rather than waiting until the CD4 count approaches or drops below 200 cells/mm3. The new guidelines also call for greater use of safer and more effective treatment regimens that are more easily tolerated, as well as expanded laboratory testing to improve the quality of treatment and care. One practical effect of these new guidelines is that it makes millions of additional HIV-positive people "eligible" for treatment.

59. The increase in treatment-eligible patients under the new treatment guidelines may pose challenging policy, financial and operational questions for national and international decision-makers. With limited budgets and rapidly increasing demand for antiretroviral treatment, decision-makers may face difficult decisions regarding which groups of patients to prioritize for antiretroviral therapy. For countries that aim to initiate antiretroviral therapy as soon as possible for the largest number of patients, this approach may require changes to national testing strategies in order to reach greater numbers of individuals with asymptomatic infection.

60. In industrialized countries, HIV treatment is considered to be lifelong. In low- and middle-income countries, the vast majority of individuals on antiretroviral therapy are on first-line regimens; WHO reports that 99 per cent of patients are receiving regimens that are consistent with international treatment guidelines. Over time, however, demand for second- and third-line regimens in resource-limited settings will inevitably grow as resistance to first-line drugs develops. In the

Khayelitsha district of South Africa, roughly one in five patients who had been started on antiretroviral therapy required second-line drugs within five years. At present, second- and third-line regimens are significantly more expensive than first-line drugs. Countries need to begin planning now for how they intend to handle the long-term demand for treatment. The public and private sectors, as well as multilateral agencies and philanthropic leaders, should redouble their collaborative efforts to ensure meaningful long-term treatment access.

61. Ensuring the sustainability of antiretroviral treatment will also require investments in new research. While the private sector has proved highly effective in producing new therapeutic compounds and in improving on existing technologies, financial incentives are not ideally aligned to maximize access and optimize medical outcomes in resource-limited settings. Simple, reliable and inexpensive diagnostics are required to help guide clinical decision-making, such as providing early evidence of drug resistance.

62. Learning one's HIV status as soon after exposure as possible permits the timely initiation of treatment and improves medical outcomes. In 39 low- and middle-income countries reporting multi-year testing data, the total reported number of HIV tests performed more than doubled between 2007 and 2008. Yet continued progress is urgently needed, as only an estimated 40 per cent of people living with HIV are thought to be aware of their serostatus.

63. Expanded access to antiretroviral treatment may also support prevention efforts. Studies in diverse settings suggest that an HIV diagnosis typically leads the individual who has tested positive to reduce his or her risk behaviours. Regular medical monitoring of HIV infection also offers new opportunities to deliver and reinforce prevention messages. Available evidence also suggests that the reduction in viral load as a result of antiretroviral therapy is likely to reduce individual infectiousness. Whether it might be possible to eliminate the epidemic through universal voluntary testing and the early initiation of treatment remains a point of extensive discussion within the field and a focus of a growing number of studies.

IV. The way forward: recommendations for action

64. Only several months remain before the deadline for the achievement of the milestones agreed in the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS. While important progress has been made with respect to international commitments on HIV, most countries are not on track to achieve universal access to HIV prevention, treatment, care and support by the end of 2010.

65. I call on all stakeholders, including national Governments, international donors, multilateral agencies and civil society organizations to renew and strengthen their commitment to achieving universal access, which should serve as a bridge towards the achievement of the Millennium Development Goals. To accelerate progress in that regard, the following actions should be urgently implemented:

(a) I call upon countries to undertake open and inclusive consultation processes, involving Governments, development partners, civil society organizations, networks of people living with HIV and community groups, to review the progress made in reaching country targets for universal access;

(b) Given the human, social and economic consequences of HIV, "business as usual" is unacceptable. All stakeholders in the HIV community should work actively to strengthen and leverage the synergistic linkages between HIV and other health and development initiatives. This will require new strategic coalitions with diverse health and development partners. International research agencies, multilateral organizations and national Governments should undertake focused collaborative research to build the evidence base for maximizing synergies between HIV programmes and other health and development efforts;

(c) I call on national Governments and international donors to significantly intensify their efforts to prevent people from becoming infected with HIV. National programmes should bring to scale strategically aligned programmes that combine biomedical, behavioural and social and structural interventions, such as the empowerment of women, stigma reduction and the protection of human rights. In the fight to prevent new infections, we all must commit to leaving behind no one, including people who inject drugs, men who have sex with men, and sex workers and their clients;

(d) All stakeholders in the HIV response should work to eliminate mother-to-child transmission, meet the unique prevention needs of young people, eradicate violence against women, and scale up social protection programmes to address the HIV-related needs of the most vulnerable, including those living in humanitarian crisis situations;

(e) While bringing first-line antiretroviral treatment to scale, countries should plan for future increased demand for second-line therapies. Treatment initiatives need to incorporate a comprehensive continuum of care, including proper nutritional support and sexual and reproductive health services. I call on all countries to commit to taking immediate action to prevent people living with HIV from dying of tuberculosis;

(f) HIV-specific programmes should leverage HIV support to strengthen national health, education and social services systems, which will require increased resources from national and global sources. National Governments and international donors should not reduce HIV spending as a result of the global economic downturn, but should commit instead to further increasing funding to meet the agreed commitments to universal access to HIV prevention, treatment, care and support. International donors should ensure full funding for the Global Fund to Fight AIDS, Tuberculosis and Malaria, and develop additional innovative financing mechanisms to ensure the long-term sustainability of the response;

(g) In anticipation of the 2011 comprehensive review of progress in implementing the 2001 Declaration of Commitment and the 2006 Political Declaration, the September 2010 high-level meeting of the General Assembly to discuss the progress made towards achieving the Millennium Development Goals should focus particular attention on the strong interlinkage between those processes.